

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                  |  |  |  |   |
|---|------------------|--|--|--|---|
| 1. DECEASED NAME (Type or Print) <b>BEULAH FOSTER BERRY</b>   |                  | 2a. DATE OF DEATH <input type="checkbox"/> KNOWN <input type="checkbox"/> ESTI- MATED <input type="checkbox"/> 1 10 69 |  | 2b. HOUR 11:15 A.M.  |   |
| 3. SEX <b>F</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>8-23-28</b>  | 6. AGE (In years last birthday) <b>40</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>             |
| 7a. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH <b>WALDORF</b>  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CHARLES WALDORF</b>                    |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLERK</b>   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |                  | 13b. COUNTY <b>CHARLES WALDORF</b>   |  | 13c. CITY OR TOWN <b>WALDORF</b>   |   |
| 14. FATHER'S NAME First <b>MAURICE</b> Middle <b>P.</b> Last <b>FOSTER</b>  |                  | 15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>A.</b> Last <b>BARBITT</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                  | 16b. SOCIAL SECURITY NO. <b>212-62-184</b>   |  | 17. INFORMANT ADDRESS <b>GARY BERRY, WALDORF, MD.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shot over left ear</b><br>965X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>C pistol</b><br>(b)<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)          |                  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-10-69</b> |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year <b>11:05 P.M. 1-10-69</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) <b>Shot &amp; pistol by husband</b>                                       |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>                               |  | 21f. LOCATION (Street or R.F.D. No. City or Town County State) <b>Waldorf Charles Md</b>   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |  |   |
| ACTUAL SIGNATURE <b>E. J. EDELEN</b>  |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED <b>1-10-69</b>  |   |
| EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>  |                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 23b. DATE <b>1-13-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEMORIAL</b>   |   |
| 24. FUNERAL DIRECTOR <b>Huntt Funeral Home Waldorf, Md. 20601</b>   |                  | 23d. LOCATION (City or Town) (County) (State) <b>WALDORF CHARLES MD</b>  |  | 25a. REC'D BY REGISTRAR <b>JAN 15 1969</b>   |   |
|   |                  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |   |

NOTES

WORLD COMMERCE FINANCE BOARD

1937

FOR THE YEAR

JAN 15 1938

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# FOR STATE HEALTH DEPT.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                  |  |  |  |  |  |  |   |  |  |
|--|--|------------------|--|--|--|--|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |  |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <u>GARY BERRY</u>  |  |                  | 2a. DATE KNOWN OF DEATH<br>Month <u>1</u> Day <u>10</u> Year <u>1969</u>                 |  |  | 2b. HOUR <u>11</u> AM  |  |  | 2c. DATE PRONOUNCED DEAD<br>Month <u>1</u> Day <u>10</u> Year <u>1969</u> |  |  |
| 3. SEX <u>M</u>  |  | 4. RACE <u>W</u> |  | 5. DATE OF BIRTH <u>1-24-21</u>  |  | 6. AGE (In years last birthday) <u>47</u> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <u>0</u> DAYS <u>0</u>   |   | IF UNDER 24 HRS.<br>HOURS <u>0</u> MIN. <u>0</u> |  |
| 7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |  |                  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <u>CHARLES</u>   |  |  |
| 10. CITY OR TOWN OF DEATH <u>WALDORF</u>   |  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) _____ |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>MANAGER</u> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>BAR</u> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>   |  |                  | 13b. COUNTY <u>CHARLES</u>   |  |  | 13c. CITY OR TOWN <u>WALDORF</u>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | 13e. STREET AND NUMBER <u>Box 202</u>            |  |
| 14. FATHER'S NAME<br>First <u>ARTHUR</u> Middle _____ Last <u>BERRY</u>  |  |                  | 15. MOTHER'S MAIDEN NAME<br>First <u>ANNIE</u> Middle <u>E.</u> Last <u>GROVES</u>       |  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>  |  |                  | 16b. SOCIAL SECURITY NO. <u>219-12-2814</u>  |  |  | 17. INFORMANT ADDRESS <u>GARY BERRY, WALDORF, MD.</u>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br><u>955X</u> IMMEDIATE CAUSE (a) <u>Heart Attack</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>due to no pump 1-10-69</u><br>(b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis</u>                    |  |                  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION _____   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____                            |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |                  | 21b. TIME OF INJURY Month, Day, Year <u>1-10-69</u> P.M. <u>1</u>                        |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Shot</u>  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u> |  |  | 21f. LOCATION (Street or R.F.D. No. _____ City or Town _____ County _____ State _____)   |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D.  |  |                  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22b. DATE SIGNED <u>1-10-69</u>   |  |  |
| EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>   |  |                  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                          |  |  |
|  |  |                  |  |  |  | ADDRESS (Street, city, town, or county) <u>LA PLATA, MD.</u>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  |                  | 23b. DATE <u>1-13-69</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>TRINITY MEMORIAL</u> |  |  | 23d. LOCATION (City or Town) (County) (State) <u>WALDORF CHAS. MD.</u>                                 |   |  |  |
| 24. FUNERAL DIRECTOR <u>Huntt Funeral Home Waldorf, Md. 20601</u>  |  |                  |  |  |  | 25a. REC'D BY REGISTRAR <u>JAN 15 1969</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |  |  |

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RECEIVED FOR RECORD AND INFORMATION  
JAN 18 1962

OUT 18

RECEIVED FOR RECORD AND INFORMATION  
JAN 18 1962

RECEIVED FOR RECORD AND INFORMATION  
JAN 18 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MARY CATHERINE BOWLING</b>  |  |  | 2a. DATE OF DEATH<br><b>Jan</b> Month <b>23</b> Day <b>1969</b> Year        |   |  | 2b. HOUR<br><b>2:10</b> M   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAU.</b>   |   | 5. DATE OF BIRTH<br><b>NOV. 13, 1887</b>  |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>CHARLES</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>LA PLATA</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>PHYSICIANS MEM. Hosp.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>CHARLES</b>  |   | 13c. CITY OR TOWN<br><b>HUGHESVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| 14. FATHER'S NAME<br>First <b>JAMES</b> Middle <b>M.</b> Last <b>BOWLING SR.</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>GERTRUDE</b> Middle <b>HAYDEN</b> Last |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.<br><b>217-36-6715</b>   |   | 17. INFORMANT<br>Address <b>GEORGE M. BOWLING SR., HUGHESVILLE, MD.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4123 Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                            |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>10 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>20 Jan</b> , 19 <b>69</b> , to <b>23 Jan</b> , 19 <b>69</b> , that (I) <del>(we)</del> saw the deceased alive on <b>22 Jan</b> , 19 <b>69</b> , and that in <del>(my)</del> <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Arthur O. Woody, MD</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>23 Jan 69</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ARTHUR O. WOODY, MD</b>   |  | 22e. ADDRESS<br><b>LA PLATA MARYLAND 20646</b>   |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-25-69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST MARYS Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BRYANTOWN, CHARLES MD.</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>HUNTT FUNERAL HOME, NALDORF, MD.</b>  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 28 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Under</b>   |  |  |  |



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| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |                                       |  |   |   |  |  |  |  |
|--|--|---------------------------------------|--|---|---|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b><br>Charles County Md  |  |                                       |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br><b>a. STATE</b> Maryland <b>b. COUNTY</b> Charles |  |  |  |  |
| <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town)<br>Faulkner  |  |                                       |  |   | <b>c. LENGTH OF STAY IN 1b</b><br>3-Months  |  |  |  |  |
| <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address)<br>Physicians Memorial LaPlata Md  |  |                                       |  |   | <b>e. IS RESIDENCE ON A FARM?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>Jonathan F. Harvey   |  |                                       |  |   | <b>4. DATE OF DEATH</b><br>Month 1-24-69 Day 19 Year 19   |  |  |  |  |
| <b>5. SEX</b><br>Male  |  | <b>6. COLOR OR RACE</b><br>Negro      |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |   | <b>8. DATE OF BIRTH</b><br>10-22-1968  |  | <b>9. AGE</b> (In years last birthday) <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b><br>yrs. 3 Months Days Hours Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>None   |  |                                       |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>None  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br>Charles County Md                |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>USA   |  |
| <b>13. FATHER'S NAME</b><br>Thomas G. Yates  |  |                                       |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br>Mary Harvey  |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |                                       |  | <b>16. SOCIAL SECURITY NO.</b><br>None  |   | <b>17. INFORMANT</b> Address<br>Mary Harvey Mother- Faulkner Md                                |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b> Influenza-<br>IMMEDIATE CAUSE (a)<br>470X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b> (b)<br><b>DUE TO</b> (c) |  |                                       |  |   |   |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br>5 Days  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |                                       |  |   |   |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                       |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)   |   |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. 19   |  |                                       |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                  |  | <b>20f. (City or town) (County) (State)</b>  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from 1-22-69, 19, to 1-24-69, 19, that (I) (we) last saw the deceased alive on 1-24-69, 19, and that death occurred at 3-20AM from the causes and on the date stated above.</b>  |  |                                       |  |   |   |  |  |  |  |
| <b>22a. SIGNATURE</b><br>   |  |                                       |  |   |   | <b>22b. DATE SIGNED</b><br>1-24-69   |  | <b>22c. PHYSICIAN'S NAME (Type)</b><br>James E. Andrews MD   |  |
| <b>22d. ADDRESS</b><br>Indian Head Md.   |  |                                       |  |   |   | <b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br>Burial   |  | <b>23b. DATE THEREOF</b><br>1/27/1969 |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>St. Ignatius Cemetery  |   | <b>23d. LOCATION (City, town or county) (State)</b><br>Bel Alton, Maryland                     |  |  |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br>Archart Funeral Home, Inc.-La Plata, Md.  |  |                                       |  |   |   | <b>25a. REC'D BY REGISTRAR</b> DATE<br>JAN 29 1969   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br>Charles J. J.   |  |

04720

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00756

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00751

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LORA LEE HUBER</b>  |  |  | 2a. DATE OF DEATH<br>1 Month 3 Day 69 Year |   |  | 2b. HOUR<br>11:30 AM   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>Dec 2, 1901</b>  |  | 6. AGE (In years last birthday)<br><b>67</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>W. VA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Charles</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>NANTHEMOY</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rt. 1 Box 251</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)<br><b>Domestic Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>CHARLES</b>  |  | 13c. CITY OR TOWN<br><b>NANTHEMOY</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>RA 1 Box 251</b>  |  | 14. FATHER'S NAME<br><b>EDWARD GEORGE</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>HUGUSTA FRANZ</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.<br><b>212-56-0211</b>   |  | 17. INFORMANT<br><b>Walter B. Huber Dr. NANTHEMOY, MD</b>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109</b> <b>Coronary occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min.</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Pneumonia, Fractured rt. hip, peptic ulcer.</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11-13-68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fractured rt. hip</b>                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br><b>5 P.M. NOV. 2 1968</b>   |  | 21b. TIME OF INJURY<br><b>5 P.M. NOV. 2 1968</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>fell at home</b>  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><b>Home</b>          |  | 21f. LOCATION Street or R.F.D. No. City or Town, County, State<br><b>Nantemoys Charles Md.</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-10, 1968</b> , to <b>1-3, 1969</b> , that (I) (we) last saw the deceased alive on <b>12-25 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>F.M. JOHNSON</b>  |  | 22c. DATE SIGNED<br><b>1-3-69</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>F.M. JOHNSON</b>   |  | 22e. ADDRESS<br><b>LA PLATA Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIED</b>   |  | 23b. DATE<br><b>1/6/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OLD DURHAM</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>IRONSIDES Charles Md.</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>Leont Funeral Home-Walkers Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>8 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |



13751

RECEIVED

13751

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|  |  |  |                  |  |   |                                  |  |  |   |  |  |                             |  |  |                                   |  |  |   |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
|--|--|--|------------------|--|---|----------------------------------|--|--|---|--|--|-----------------------------|--|--|-----------------------------------|--|--|---|--|--|----------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|--|
| 00757  |  |  |                  |  |   |                                  |  |  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                             |  |  |                                   |  |  |   |  | 00752  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or Print) <b>SIDNEY AUGUSTINE JENKINS</b>   |  |  |                  |  |   |                                  |  |  |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>1 28 69 9 PM</b>                    |  |                             |  |  |                                   |  |  |   |  | 2b. HOUR   |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>M</b>  |  |  | 4. RACE <b>W</b> |  |   | 5. DATE OF BIRTH <b>1-7-1898</b> |  |  | 6. AGE (In years last birthday) <b>71 YRS</b> |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  | IF UNDER 24 HRS. HOURS MIN.       |  |  | 2c. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>28</b> Year <b>69 9 PM</b> |  |  | 2d. HOUR |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> |                                  |  |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                             |  |  | 9. COUNTY OF DEATH <b>CHARLES</b> |  |  |   |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>LAPLATA, MARYLAND</b>   |  |  |                  |  |   |                                  |  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MARYSKIAN'S MEMORIAL</b>   |  |                             |  |  |                                   |  |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMING TOBACCO</b> |          |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  |  |                  |  |   |                                  |  |  |   | 13b. COUNTY <b>CHARLES</b>   |  |                             |  |  |                                   |  |  |   |  | 13c. CITY OR TOWN <b>HUGHESVILLE</b>   |          |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER          |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <b>Wm.</b> Middle <b>W.</b> Last <b>JENKINS</b>  |  |  |                  |  |   |                                  |  |  |   | 15. MOTHER'S MAIDEN NAME First <b>LULA</b> Middle <b>BURCH</b> Last <b>JENKINS</b>   |  |                             |  |  |                                   |  |  |   |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>   |  |  |                  |  |   |                                  |  |  |   | (If yes give war or dates of service)  |  |                             |  |  |                                   |  |  |   |  | 16b. SOCIAL SECURITY NO. <b>217-36-7599</b>  |          |  |  |  |  |  |  |  |  | 17. INFORMANT <b>MRS ETTA JENKINS</b>  |  |  |  |  |  |  |  |  |  | ADDRESS <b>HUGHESVILLE, MD.</b> |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109 Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>1-28-19</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |                  |  |   |                                  |  |  |   |  |  |                             |  |  |                                   |  |  |   |  |  |          |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                  |  |   |                                  |  |  |   |  |  |                             |  |  |                                   |  |  |   |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |                  |  |   |                                  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                             |  |  |                                   |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |                  |  |   |                                  |  |  |   | 21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.  |  |                             |  |  |                                   |  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |                  |  |   |                                  |  |  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |                             |  |  |                                   |  |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |                  |  |   |                                  |  |  |   |  |  |                             |  |  |                                   |  |  |   |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>E. J. EOLEN</b>  |  |  |                  |  |   |                                  |  |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |                             |  |  |                                   |  |  |   |  | 22b. DATE SIGNED <b>1-29-69</b>  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>E. J. EOLEN</b>  |  |  |                  |  |   |                                  |  |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |                             |  |  |                                   |  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| ADDRESS (Street, city, town, or county)  |  |  |                  |  |   |                                  |  |  |   |  |  |                             |  |  |                                   |  |  |   |  |  |          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |                  |  |   |                                  |  |  |   | 23b. DATE <b>1-31-69</b>   |  |                             |  |  |                                   |  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>   |          |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>BRYANTOWN, CHARLES</b>                      |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME WALDORF, MD</b>  |  |  |                  |  |   |                                  |  |  |   | ADDRESS  |  |                             |  |  |                                   |  |  |   |  | 25a. REC FEB 3 1969 GISTRAR'S SIGNATURE  |          |  |  |  |  |  |  |  |  | DATE   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |

00752

UNITED STATES DEPARTMENT OF THE INTERIOR

FOR SALE  
UNITED STATES

GOVT. PRINTING OFFICE

FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                     |   |  |   |   |  |  |   |                                       |  |
|---|---------------------|---|--|---|---|--|--|---|---------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>George Edward Kohlieber Jr.</b>  |                     |   | First Middle Last                              |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>12</b> Day <b>28</b> Year <b>1969</b> |  | 2b. HOUR <b>19</b> M <b>M</b>   |                                       |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>2-10-29</b>  | 6. AGE (In years)<br><b>39</b> YRS             | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>                       | 2c. DATE PRONOUNCED DEAD<br>Month <b>1</b> Day <b>28</b> Year <b>1969</b>                                  |  | 2d. HOUR <b>5:45 PM</b> M <b>M</b>  |                                       |  |
| 7a. BIRTHPLACE (State or foreign)<br><b>Kansas</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 9. COUNTY OF DEATH<br><b>Charles County Md.</b>  |  |   |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Waldorf Md.</b>   |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>No</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired USAF</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>USAF</b>   |  |   |                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>   |                     |   | 13b. COUNTY <b>Charles</b>                     |   | 13c. CITY OR TOWN <b>Waldorf</b>                                    |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>None</b> |  |
| 14. FATHER'S NAME<br><b>George E. Kohlieber Sr.</b>   |                     |   | First Middle Last                              |   |   | 15. MOTHER'S MAIDEN NAME<br><b>Christine Keger</b>   |  |   | First Middle Last                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>yes</b>   |                     |   | 16b. SOCIAL SECURITY NO.<br><b>514-20-3445</b> |   | 17. INFORMANT ADDRESS<br><b>Wife-Martha E. Kohlieber=Waldorf Md</b> |  |  |   |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound Upper Right Chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Self Inflicted</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                     |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>                    |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                     |   |  |   |   |  |  |   |                                       |  |
| 19a. DATE OF OPERATION  |                     |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M. <b></b>                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Self Inflicted Gun Shot Wound</b>   |   |  |  |   |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)              |  | 21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>  |   |  |  |   |                                       |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                     |   |  |   |   |  |  |   |                                       |  |
| ACTUAL SIGNATURE<br><b>James E. Andrews ND.</b>   |                     | EXAMINER'S NAME (Type)<br><b>James E. Andrews ND.</b>                                     |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county)<br><b>Indian Head Md.</b> |   | 22b. DATE SIGNED<br><b>1-29-69</b>   |  |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                     | 23b. DATE<br><b>2-3-1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington Va.</b>                                      |  |   |                                       |  |
| 24. FUNERAL DIRECTOR<br><b>Huntt Funeral Home Waldorf, Md. 20601</b>  |                     |   |  | ADDRESS<br><b></b>  |   | 25a. REC'D BY REGISTRAR<br><b>FEB 4 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William A. Underhill</b>                           |                                       |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00753

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

Washington, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00759

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00754

|   |                             |  |                                      |   |   |   |   |
|---|-----------------------------|--|--------------------------------------|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print)   |                             | First<br><b>PETER</b>  | Middle<br><b>H.</b>                  | Last<br><b>Krex</b>   | 2a. DATE OF DEATH<br>Jan 19 1969        |   | 2b. HOUR<br>7:50PM  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>Caucasian</b> |  | 5. DATE OF BIRTH<br><b>19 Jan 69</b> |   | 6. AGE (In years last birthday)<br>YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Charles</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>La Plata</b>  |                             | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Physicians Memorial</b> |                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Infant</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution) State<br><b>Md.</b>   |                             | 13b. COUNTY<br><b>Charles</b>  |                                      | 13c. CITY OR TOWN<br><b>Pisgah</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 13e. STREET AND NUMBER  |                             | 14. FATHER'S NAME<br>First Middle Last<br><b>Peter Hartmut Krex</b>  |                                      | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Elizabeth Michelle Lopez</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                             | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |                                      | 17. INFORMANT<br>Address<br><b>Peter H. Krex, Sr. - Father - Pisgah, Md.</b>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br><b>777x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                      |                             |  |                                      |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |                             |  |                                      |   |   |   |   |
| 19a. DATE OF OPERATION  |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                             | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                             | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                                      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 Jan</b> , 19 <b>69</b> , to _____, 19____, that (I) ( <del>we</del> ) last saw the deceased alive on <b>19 Jan</b> 19 <b>69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death. |                             |  |                                      |   |   |   |   |
| 22b. SIGNATURE<br><b>J.B. Mason MD</b>  |                             |  |                                      | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |   | 22c. DATE SIGNED<br><b>19 Jan 69</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J.G. Barry Mason MD</b>  |                             |  |                                      | 22e. ADDRESS<br><b>P.O. Box 937, La Plata, Md. 20646</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                             | 23b. DATE<br><b>1/21/1969</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Rest Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>La Plata, Maryland</b>                      |   |
| 24. FUNERAL DIRECTOR<br><b>Arehart Funeral Home, Inc. - La Plata, Md.</b>   |                             |  |                                      | 25a. DEED BY REGISTRAR<br><b>JAN 23 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |

RECEIVED OCT 15 1964

TO: DIRECTOR, FBI (100-388610)

FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY, AKA; MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER 14, 1964.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON OCTOBER 14, 1964, THE NEW YORK OFFICE RECEIVED A TELEPHONE CALL FROM AN INDIVIDUAL WHO IDENTIFIED HIMSELF AS JAMES EARL RAY.

THE INDIVIDUAL STATED THAT HE WAS CURRENTLY IN NEW YORK CITY AND WANTED TO SPEAK TO THE DIRECTOR OF THE FBI.

THE NEW YORK OFFICE ATTEMPTED TO LOCATE THE INDIVIDUAL BUT WAS UNABLE TO DO SO.

THE NEW YORK OFFICE IS CURRENTLY ATTEMPTING TO LOCATE THE INDIVIDUAL AND WILL REPORT THE RESULTS OF ITS EFFORTS TO THE BUREAU.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00755

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>CHARLES</b> First <b>EDWARD</b> Middle <b>SAVOY, JR.</b> Last   |  |   |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>Jan. 19, 69</b>         |  |   |  | 2b. HOUR <b>11:45A</b>  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Negro</b>  |  | 5. DATE OF BIRTH <b>9/15/47</b>   |  | 6. AGE (In years last birthday) <b>22</b> YRS.  |  | 7c. DATE PRONOUNCED DEAD<br>Month <b>Jan.</b> Day <b>19,</b> Year <b>1969</b>     |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Charles</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Waldorf</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>301 Drive In Theater</b>    |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |   |  | 13b. COUNTY <b>Charles</b>  |  | 13c. CITY OR TOWN <b>Upper Marlboro</b>   |  | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 14. FATHER'S NAME <b>CHARLES E. SAVOY SR</b> First <b>CHARLES</b> Middle <b>E.</b> Last <b>SAVOY SR</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME <b>FRANCES SAVOY</b> First <b>FRANCES</b> Middle <b>SAVOY</b> Last   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>FRANCIS SAVOY</b> ADDRESS <b>PA Geo Co</b>                             |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY: <b>Carbon Monoxide Poisoning</b><br>IMMEDIATE CAUSE (a) <b>873X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year <b>11:45x 1/19/ 19 69</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Inhalation of carbon monoxide</b>                                     |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>301 Drive In Theater</b> |  | 21f. LOCATION Street or R.F.D. No. <b>Waldorf/Upper Marlboro</b> City or Town <b>Charles</b> County <b>M.D.</b> State                                       |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED <b>1/20/69</b>   |  |
| EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |  |
|  |  |   |  | ADDRESS (Street, city, town, or county)   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <b>1-23-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>  |  | 23d. LOCATION (City or Town) <b>CLINTON</b> (County) <b>MD.</b> (State)                 |  |   |  |
| 24. FUNERAL DIRECTOR <b>ARCHART</b>  |  |   |  | 24b. ADDRESS <b>LA PLATA MD</b>   |  | 25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>William Judge</b>                                   |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |   |   |  |
|--|--|--|--|--|---|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |   |   |   |   |  |
| 1. DECEASED-NAME (Type or Print) <b>IRINE SAVOY</b>  |  |  |  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>Jan. 19, 1969</b> |   |   | 2b. HOUR <b>11:45</b>   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Negro</b>   |  | 5. DATE OF BIRTH <b>6/12/50</b>  |   | 6. AGE (In years last birthday) <b>18</b> YRS.  |   | 7c. DATE PRONOUNCED DEAD Month <b>Jan.</b> Day <b>19,</b> Year <b>1969</b>        |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Charles</b>   |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Waldorf Upper Marlboro</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>301 Drive In Theater</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Charles</b>   |  |   | 13c. CITY OR TOWN <b>Upper Marlboro</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First <b>JOHN A.</b> Middle <b>GREEN</b> Last <b>VIRGINIA</b>  |  |  | 15. MOTHER'S MAIDEN NAME First <b>THOMPSON</b> Middle <b>THOMPSON</b> Last <b>THOMPSON</b>               |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>CHARLES GREEN</b>  |  |   | 17. INFORMANT ADDRESS <b>VIRGINIA GREEN R. Geor MD.</b>                                 |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |  | 21b. TIME OF INJURY Month, Day, Year <b>11:45 PM 1/19/ 1969</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Inhalation of carbon monoxide</b>                              |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>301 Drive In Theater</b> |  |  | 21f. LOCATION Street or R.F.D. No. <b>Waldorf Upper Marlboro</b>  |   | City or Town <b>Charles</b>               |   | State <b>M.D.</b>                            |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>   |  |  | M.D. <b>Ronald N. Kornblum, M.D.</b>   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>1/20/69</b>   |  |
| EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>   |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |   | ADDRESS (Street, city, town, or county)   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <b>1-23-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>   |   | 23d. LOCATION (City or Town) <b>CLINTON</b>   |   | (County) <b>MARYLAND</b> (State)  |  |
| 24. FUNERAL DIRECTOR <b>ARCHART. LAPATA MD</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles</b> |   |  |



[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00757  
**CERTIFICATE OF DEATH**

|   |  |   |   |  |
|---|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Nettie F. Scott</b>  |  | 2a. DATE OF DEATH<br>Month <b>January</b> Day <b>19</b> Year <b>1969</b>  |   | 2b. HOUR<br><b>1:55AM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>2/11/90</b>  | 6. AGE (In years<br>last birthday)<br><b>78</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN.               |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Charles County</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>La Plata</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Physicians Memorial Hosp</b> | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>HW</b>   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Charles</b>  | 13c. CITY OR TOWN<br><b>Nanjemoy</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET AND NUMBER   |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Franklin</b> Last  | 15. MOTHER'S MAIDEN NAME<br>First <b>Charlotte</b> Middle <b>Welch</b> Last  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br><b>215-54-6761</b>   | 17. INFORMANT<br>Address<br><b>Lester Scott, Box 419, La Plata, Md.</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4123 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <b>Chronic Heart Disease - 2-4 days</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/26, 1968</b> , to <b>1/19, 1969</b> , that (I) (we) last saw the deceased alive on <b>1/19, 1969</b> , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |
| 22b. SIGNATURE<br><b>Arturo M. Monteiro, M.D.</b>   |  | DEGREE  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><b>1/21/69</b>   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Arturo M. Monteiro</b>   |  | 22e. ADDRESS<br><b>La Plata Md. 20646</b>   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Jan. 21, 1969</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nanjemoy Baptist</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Nanjemoy Charles, Md.</b>        |
| 24. FUNERAL DIRECTOR<br><b>Arehart Funeral Home Inc., La Plata, Md.</b>   |  | ADDRESS<br><b>La Plata, Md.</b>   |   | 25. JAN 23 1969<br>DATE  |

12500

10/10/00

11-10-19-100

ST-100-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 00763  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 00758                           |  |  |  |  |                             |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH Month Day Year   |  |  |  |  |  |  |  |  |  | 2b. HOUR M                      |  |  |  |  |                             |  |  |  |  |
| Elizabeth SMOOT  |  |  |  |  |   |  |  |  |  | 1-11-69  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 3. SEX Female  |  |  |  |  | 4. RACE Colored   |  |  |  |  | 5. DATE OF BIRTH 4-10-1887   |  |  |  |  | 6. AGE (In years last birthday) 81 YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS     |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH Charles Md.   |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH LA PLATA   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4100 |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE MD  |  |  |  |  | 13b. COUNTY Charles   |  |  |  |  | 13c. CITY OR TOWN LA PLATA   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER LA PLATA |  |  |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME First Middle Last Charles Hawkins  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Bettie Yates                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO   |  |  |  |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)                    |  |  |  |  | 17. INFORMANT Louise Woodland  |  |  |  |  | Address LA PLATA   |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Hypertensive Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years. |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                              |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)      |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/14/1965, to 1/14/1969, that (I) (we) lost the deceased alive on 12/23/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 22b. SIGNATURE Frank A. Sason M.D.   |  |  |  |  | DEGREE  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  |  |  | 22c. DATE SIGNED 1/13/69   |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Frank A. Sason M.D.   |  |  |  |  | 22e. ADDRESS Rt. 1 Box 50 Indian Head Md  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE 1-14-69   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY St. Josephs   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) Pomoret MD                                     |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |
| A Rehart Funeral Home  |  |  |  |  |   |  |  |  |  | JAN 16 1969  |  |  |  |  | Charles Judge  |  |  |  |  |                                 |  |  |  |  |                             |  |  |  |  |

83700

STATE OF TEXAS

3700

ORIGINAL FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M  
30M REV. 1-58

| 00764  |                           | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                        |   | 00759  |  |
|--|---------------------------|--|---|--|--|
| Item 11 Film G409 2/19/69 kk   |                           |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Jones Clarence Swann</i>  |                           |  | 2a. DATE OF DEATH<br>Month <i>January</i> Day <i>9</i> Year <i>1969</i>   |  | 2b. HOUR<br><i>3:30 A</i> M              |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>Colored</i> | 5. DATE OF BIRTH<br><i>July 6, 1905</i>  |   | 6. AGE (In years last birthday)<br><i>63</i> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Ches. County Md</i>  |                           | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Charles</i> Md. |
| 10. CITY OR TOWN OF DEATH<br><i>Md. Md. Md.</i>  |                           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>P.O. Box 68</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Truckerman</i>       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>   |                           | 13b. COUNTY<br><i>Charles</i>  | 13c. CITY OR TOWN<br><i>Md. Md.</i>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 14. FATHER'S NAME First <i>Leonard</i> Middle <i>Swann</i> Last <i>Swann</i>   |                           | 15. MOTHER'S MAIDEN NAME First <i>Katie</i> Middle <i>Swann</i> Last <i>Swann</i>                  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) |  |
| 16b. SOCIAL SECURITY NO.<br><i>579-16-9293</i>   |                           | 17. INFORMANT Address<br><i>Mrs. James C. Swann P.O. Box 68, Md. Md.</i>                           |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Hypertensive Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immediate</i><br><i>3 years</i> |                           |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                           |  |   |  |  |
| 19a. DATE OF OPERATION   |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                           |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                           | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                           | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1965</i> , to <i>Jan. 1969</i> , that (I) (we) lost the deceased alive on <i>Dec 20</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                           |  |   |  |  |
| 22b. SIGNATURE<br><i>Frank A. Susan</i>  |                           | 22c. DATE SIGNED<br><i>1-9-69</i>  |   | 22d. PHYSICIAN'S NAME (Type)<br><i>Frank A. Susan M.D.</i>   |  |
| 22e. ADDRESS<br><i>Rt. 1 Box 50 Indian Head, Md. 20640</i>   |                           |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 23b. DATE<br><i>Jan. 13/69</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Alexandria Ch. Cemetery</i>   |  |
| 23d. LOCATION (City or Town) (County) (State)<br><i>Chicasso Chas Co. Md.</i>  |                           | 23e. REC'D BY REGISTRAR<br><i>Charles Judge</i>  |   |  |  |
| 24. FUNERAL DIRECTOR<br><i>Martell Adams</i>   |                           | 24a. ADDRESS<br><i>Aquasco, Md.</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |

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UNITED STATES DEPARTMENT OF JUSTICE

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